

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

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15. DATE SUBMITTED:

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FOR REGIONAL OFFICE USE ONLY

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PLAN APPROVED - ONE COPY ATTACHED

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20. SIGNATURE OF REGIONAL OFFICIAL:

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21. TYPED NAME:

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22. TITLE:

Deputy Director, CMSO

23. REMARKS:

RECEIVED

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAMMETHODS OF IMPLEMENTATION FOR WISCONSIN MEDICAID NURSING HOME PAYMENT RATES
FOR THE PERIOD JULY 1, 2002 THROUGH JUNE 30, 2003

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SECTION 1.000 INTRODUCTION

1.110 General Purpose

The purpose of the Wisconsin Medicaid Methods of Implementation for Medicaid Nursing Home Payment Rates is to ensure that nursing homes, including nursing facilities (NF), and intermediate care facilities for the mentally retarded (ICF-MR), are paid appropriately for care provided to Medicaid residents in a cost-efficient fashion.

Wisconsin nursing homes participating in Wisconsin Medicaid are paid by a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. This methodology must meet federal standards and is established in the Methods issued annually by the Wisconsin Department of Health and Family Services, hereafter known as the Department. Within the Department, the Division of Health Care Financing (DHCF) has primary responsibility for establishing nursing home payment rates.

The Department shall develop such administrative policies and procedures as are necessary and proper to implement the provisions outlined in the Methods. This information shall be communicated to the nursing home industry as necessary, such as through program memoranda, provider handbooks, and Medicaid Updates. Such policies and procedures are generally intended to apply to usual and customary situations and are not necessarily applicable to special situations and circumstances. Any questions regarding specific circumstances should be referred to the Department.

It should be noted that the Department develops standardized calculation worksheets for the computation of payment rates under the Methods. These worksheets are an administrative tool and are generally intended to apply only to usual and customary situations.

1.115 Further Information

For further information, contact:

Nursing Home Section
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Individual nursing homes should contact their district Medicaid auditor for specific questions on their payment rates.

1.120 Basis of the Nursing Home Payment Rates

Allowable payment levels were determined by the Department through examination of costs actually incurred by a sample of nursing homes in Wisconsin. Appropriate adjustments for actual and anticipated inflation levels were taken into account in projecting costs. One provision in these Methods helps assure that necessary and appropriate care continues to be provided by facilities which may not be economically and efficiently operated and which face unique fiscal circumstances. The Nursing Home Appeals Board helps ensure cost-effective operations and yet recognize exceptional circumstances, if warranted.

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute 49.45(6m)(e) shown below.

49.45(6m)(e) The department shall establish an appeals mechanism within the department to review petitions from facilities providing skilled, intermediate, limited, personal or residential care or providing care for the mentally retarded for modifications to any payment under this subsection. The department may, upon the presentation of facts, modify a payment if demonstrated substantial inequities exist for the period appealed. Upon review of the department's decision the secretary may grant the modifications, which may exceed maximum payment levels allowed under this subsection but may not exceed federal maximum reimbursement levels. The department shall develop specific criteria and standards for granting payment modifications, and shall take into account the following, without limitation because of enumeration, in reviewing petitions for modification:

1. The efficiency and effectiveness of the facility if compared with facilities providing similar services and if valid cost variations are considered.
2. The effect of rate modifications upon compliance with federal regulations authorized under 42 USC1396 to 1396p.
3. The need for additional revenue to correct licensure and certification deficiencies.
4. The relationship between total revenue and total costs for all patients.
5. The existence and effectiveness of specialized programs for the chronically mentally ill or developmentally disabled.
6. Exceptional patient needs.
7. Demonstrated experience in providing high quality patient care.

1.130 Authority and Interpretation of 2002-2003 Methods

These Methods will determine payment for services provided during the twelve-month time period of July 1, 2002, through June 30, 2003, unless otherwise modified by legislative action, or federal or court direction. A new rate period begins with services rendered on or after July 1, 2003.

1.131 Severability

The provisions of the Methods of Implementation for the Medicaid Nursing Home Payment Rates are to be considered separate and severable.

1.132 Effective Period of Payment Rates

Rates shall be implemented on or after July 1, 2002, unless otherwise specified. Rates issued after July 1, 2002, shall be approved retroactively to July 1, 2002. However, rates may be approved effective on a later date under the provisions of Section 4.000 Rate Adjustments and Recalculations of these Methods.

1.133 Authority of 2003-2004 Methods

Applicable nursing home payment rates for services rendered on or after July 1, 2003, will be governed by the provisions of a separate, new 2003-2004 Methods, even if the 2003-2004 Methods are issued subsequent to July 1, 2003. Reimbursement rates established under one Methods will apply only to that reimbursement period.

1.134 Recoupment of Overpayment

Upon a rate decrease for any purpose, any excess payments for previously provided services shall be recovered from the provider. The amount to be recovered shall be determined by the Department or its fiscal agent. The amount shall be recovered within a recovery period not to exceed 60 days. Requests for a recovery period should be submitted to the fiscal agent.

As a standard procedure, the Department will recover the recovery amount by deducting, from each current remittance to the provider, a fixed percentage of each remittance. The Department shall establish the fixed percentage. If the total amount is not fully recovered within the first 30 days of the recovery period, then the Department may establish larger repayment installments in order to assure the total amount is fully recovered by the end of the 60 day recovery period.

If enough Accounts Receivable shall not be generated by the fiscal intermediary to recover 100% of the funds within 60 days, a lump sum payment shall be made to the Department for the difference. In addition, if the Department's fiscal agent cannot determine the amount of the recovery, the amount will be determined by the Department. In these situations, the recovery amount shall also be recovered within 60 days and may either be deducted from current remittances to the provider or repaid by the provider to the Department's fiscal agent.

1.140 Litigation

The State has been or may be involved in litigation concerning the validity or application of provisions contained in this Methods or provisions of previous Methods. Medicaid payments resulting from entry of any court order may be rescinded or recouped, in whole or in part, by the Department if that court order is subsequently vacated, reversed or otherwise modified, or if the Department ultimately prevails in litigation. When recoupment occurs, recoupment will be made from all facilities affected by the issuance of the court order, whether or not such facilities were parties to the litigation. If any provision of this Methods is properly and legally modified or overturned, the remaining provisions of this Methods are still valid.

1.160 Medicaid Participation Requirements

All nursing homes participating in the Medicaid program must meet established certification requirements, adopt a uniform accounting system, file a cost report, and disclose the financial and other information necessary for verification of the services provided and costs incurred. The Department will specify the time periods and forms used for those purposes.

1.170 Cost and Survey Reporting Requirements1.171 Cost Reporting

All certified nursing home providers must annually submit a "Medicaid Nursing Home Cost Report" for the period of the home's fiscal year. Under special circumstances, the Department may require or allow a provider to submit a cost report for an alternative period of time. A standardized cost reporting form and related instruction booklet, which include detailed policies and instructions for cost reporting, are provided by the Department. This cost report and the related cost report instruction booklet along with policies adopted by the Department, are an integral and important part in determining payment rates. Additionally, the Department may require providers to submit supplemental information beyond that which is required in the cost report form. Supplemental information

concerning related entities shall be made available on request. The intent of cost reporting is to identify the costs incurred by the nursing home provider to be used in the application of the Medicaid payment policies and methodology.

1.171(b) All Certified Nursing Home Providers Must Submit

An annual survey of nursing homes on report forms and/or in an electronic format that meets the Department's specifications. The Annual Survey of Nursing Homes report form options and instructions are provided by the Department. Reports must be based on the calendar year or the portion of the calendar year during which the nursing home was in operation.

1.172 Signature

If the cost report or annual survey is prepared by a party other than the nursing home owner or a nursing home employee, it must be signed by both the preparer and the owner/employee.

1.173 Timely Submission

The completed cost report is due to the Department within three months after the end of the cost reporting period unless the Department allows additional time. The due date of supplemental information, including responses to DHCF questions, will depend on the complexity and need for the information being required. The due dates for cost reports for the Nursing Home Appeals Board shall be established by the Board and may be less than three months. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit cost reports and required supplemental information and responses to DHCF questions by the due dates.

The completed Annual Survey of Nursing Homes is due to the Department by February 1 of each year, unless the Department allows a maximum 28 day extension. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit annual survey forms and respond to the Department by the due date.

Failure to pay the Occupied Bed Assessment in a timely fashion will also cause the Department to withhold payment to a provider.

Facilities that do not meet the requirements of this section will have payment rates reduced according to the following schedule:

- 25% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 1 and 30 days overdue.
- 50% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 31 and 60 days overdue.
- 75% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 61 and 90 days overdue.
- 100% for cost reports, supplemental information, occupied bed assessments and/or annual surveys more than 90 days overdue.

The number of days overdue shall be measured from the original due date, without extension, of the cost report, supplemental information, occupied bed assessment and/or nursing home survey.

The rates will be retroactively restored once the cost report, supplemental information, occupied bed assessment and/or nursing home survey is submitted to the Department.

1.174 Records Retention

Providers must retain all financial records, statistical records and worksheets to support their cost report and supplemental information for a period of five years. (Reference: HFS 105.02, Wis. Adm. Code). Records and worksheets must be accurate and in sufficient detail to substantiate the reported financial and statistical data. These records must be made available to the Department or the United States Department of Health and Human Services within a reasonable time from the date of request and at a location within Wisconsin unless alternative arrangements can be made with the Department. Failure to adequately support reported amounts may result in retroactive reductions of payment rates and recoveries of monies paid for services.

1.175 Change of Ownership

Upon change of ownership of a nursing home operation, the prior owner is required to submit a cost report for the fiscal period prior to the ownership change unless the Department determines the cost report is not needed. The prior owner's failure to submit such a cost report may limit the new provider's payment rates. IT IS IMPORTANT THAT THE NEW OWNER ASSURE THAT THE PRIOR OWNER SUBMITS THE COST REPORT. Also see Sections 4.200 through 4.230.

1.176 Combined Cost Report for Multiple Providers

A separate cost report is to be submitted by each separately certified nursing home provider. Nevertheless, the Department may allow or require two or more separately certified providers to submit a single combined cost report in the following circumstances:

1. Multiple Certified Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes which are located on the same or contiguous property and which are fully owned by the same corporation, governmental unit or group of individuals.
2. Small Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes when each has a capacity of less than 25 licensed beds and when all are fully owned by the same corporation, governmental unit or group of individuals.
3. Distinct Part ICF-MRs. A provider operating in conjunction with a distinct part ICF-MR provider, as defined in Section 1.311, shall be required to submit a combined cost report for both providers.
4. Distinct Part IMDs. A provider operating in conjunction with a distinct part institution for mental disease (distinct part IMD) provider, as defined in Section 1.312, shall submit a combined cost report. However, the Department may require separate cost reports depending on individual circumstances.

The Department shall not allow a combined cost report for a facility if the Department estimates that payment rates which are determined from such a report are likely to result in payments which are substantially in excess of the amount which would be paid if separate cost reports were submitted. The Department shall not allow a combined cost report if a facility's rates cannot be readily or appropriately calculated based on such a report.

1.200 ALLOWABLE EXPENSES

1.210 Patient Care Related Expenses

Only expenses incurred by the nursing home related to nursing home patient care shall be allowable for payment. Expenses related to patient care include all necessary and proper expenses which are appropriate in developing and maintaining the operation of nursing home facilities and services. Necessary and proper expenses are usually expenses incurred by a reasonably prudent buyer which are common and accepted occurrences in the operation of a nursing home.

1.215 Sanctions

Allowable expenses do not include forfeitures, civil money penalties or fines assessed under Wisconsin Statutes, Administrative Rules, Federal Regulations or local ordinances.

1.220 Bad Debts

Bad debts and charity and courtesy allowances applicable to any patient shall not be allowable expenses.

1.230 Prudent Buyer

The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing cost. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicaid providers of services will also seek them.

The Department may employ various means for detecting and investigating situations in which costs seem excessive. These techniques may include, but are not limited to, comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers; spot-checking; and querying providers about direct and indirect discounts. In those cases where the Department notes that a provider pays substantially more than the going price for a supply or service in the absence of clear justification for the premium, the Department will exclude excess costs in determining allowable costs for payment rates.

1.240 Approvals under the State's Resource Allocation Program: Long-Term Care

Unless otherwise specified in this Methods, payment shall not be provided for expenses related to capital projects or changes in service which were not approved or for which notice was not given (if required) under Section 1122 of the Social Security Act or Chapter 150, Wis. Stats.

The Department shall retroactively reverse or negate the effect of rate adjustments due to a Resource Allocation Program project if the facilities did not complete the projects.

1.241 Workers Compensation

By Statute, nursing homes are required to provide Workers Compensation (WC) insurance for their employees. The Wisconsin Compensation Rating Bureau (WCRB) has the authority to establish rates for WC insurance. The allowed WC cost will be the lesser of the calculated amounts obtained from the WCRB WC policy for a given nursing home or allowable cost of a self insurance plan.

WC expenses may need to be accrued on an estimated basis since subsequent audit may result in an adjustment to the Experience Modification Factor (EMF) resulting in additional costs or refunds for the cost reporting period. Allowed WC expense will be the

amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated Workers Compensation amounts that result in additional costs or refunds shall be reported as an addition or reduction of WC expense in the cost reporting period that they become known.

1.245 Legal and Other Professional Fees

Under the following circumstances, legal and other professional fees incurred by a provider are not related to patient care and are thus not allowable expenses:

1. The provider (or an organization of which a provider is a member) incurs the fees for the prosecution or defense or potential prosecution or defense of any administrative appeal or judicial suit which results from any reimbursement action taken by a state or federal agency administering Title XVIII or Medicaid programs.
2. The provider (or an organization of which a provider is a member) incurs the fees in an administrative appeal or judicial suit which results from any action by the state agency that administers licensing and certification requirements, unless the administrative law judge in the administrative appeal awards fees in a motion brought under Section 1.2455.
3. The provider incurs fees defending an owner or an employee in any personal matter or in any criminal investigation or prosecution.
4. The provider incurs the fees in any other remedial process pursued prior to the filing of an appeal under chs. 50 or 227, Wis. Stats., or a judicial suit.
5. Other fees not related to patient care.

1.2455 Award of Fees

The treatment of legal fees and other professional fees incurred in a provider's administrative appeal of any action by a state agency that administers licensing and certification requirements shall be as follows:

1. Upon resolution of any such appeal, the provider or the state agency may submit a motion for award of fees to the administrative law judge. The judge shall award fees if the judge determines that the moving party is the "prevailing party," unless the judge determines that the other party had a reasonable basis in law and fact for taking its position or that special circumstances exist that would make an award unjust. The judge shall determine the prevailing party and the amount of the award pursuant to ss. 227.485(4) and 814.245(5), Stats., except that the amount of the award shall not include any fees associated with preparing, submitting or litigating the motion for fees. The judge's decision is not subject to judicial review.
2. If the fees are awarded to the provider under this section, the amount awarded will be treated as an allowable expense in the cost report year or years in which the fees were incurred, to the extent the amount does not exceed the Administrative and General cost center maximum limitation under Section 3.250 of the Methods. If the fees are awarded to the Department in its role as state licensing or certification agency, the amount awarded will be deducted from the provider's otherwise allowable costs in the Administrative and General cost center for the cost report year or years in which the fees were incurred.
3. Section 227.485, Stats., is intended to allow an administrative law judge to award costs associated with a hearing to the prevailing party in the proceeding, upon motion of that party, but it only allows such awards for individuals, small non-profit corporations, or small businesses. Providers who are individuals, small non-profit corporations or small businesses, and who pursue costs under s. 227.485, Stats., shall not be entitled to, in addition, pursue costs under the provisions of this state plan.

1.246 Accruals of Paid Time Off

The Department will not recognize the accruals of expenses for paid time off. It will recognize only the cost of paid time off (i.e. vacations, sick leave, etc.) which has been paid during the cost reporting period.

1.247 On-Premise Time Off

On-premise paid time off (i.e., break time, paid meal time, etc.) should be reported as productive time and wages.

1.248 Self-Insurance Costs

The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self insurance allowable cost determination, it must be